		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

IDPA ID Number: 370661224-001

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501©3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RUTH STOWE **Telephone Number:** 217-223-2636 EXT 311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/99 to 9/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JUDY KIRLIN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ 12/22/00 (Date)
(Print Name and Title) TIMOTHY WIEWEL, PROPRIETOR
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 92598

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	138	Intermediate (ICF)	138	50,508	3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,136	5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,598	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	568	411	799	1,778	8
9	SNF/PED					9
10	ICF	20,026	29,061		49,087	10
11	ICF/DD					11
12	SC	3,477	14,343		17,820	12
13	DD 16 OR LESS					13
14	TOTALS	24,071	43,815	799	68,685	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.18%

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
INDEPENDENT LIVING UNITS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 6 and days of care provided 799

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	427,546	30,314	25,394	483,254		483,254		483,254			1
2	Food Purchase		231,915		231,915		231,915		231,915			2
3	Housekeeping	192,480	37,312	10,438	240,230		240,230		240,230			3
4	Laundry	78,236	28,485	2,026	108,747		108,747		108,747			4
5	Heat and Other Utilities			263,319	263,319		263,319		263,319			5
6	Maintenance	123,332	34,582	75,291	233,205		233,205		233,205			6
7	Other (specify):*											7
8	**TOTAL General Services**	821,594	362,608	376,468	1,560,670		1,560,670		1,560,670			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,566,873	100,728	5,313	2,672,914		2,672,914		2,672,914			10
10a	Therapy	117,540	316	29,795	147,651		147,651		147,651			10a
11	Activities	116,589	4,089	17,089	137,767		137,767		137,767			11
12	Social Services	51,253		1,350	52,603		52,603		52,603			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,852,255	105,133	53,547	3,010,935		3,010,935		3,010,935			16
	C. General Administration											
17	Administrative	70,863			70,863		70,863		70,863			17
18	Directors Fees											18
19	Professional Services			25,444	25,444		25,444	(805)	24,639			19
20	Dues, Fees, Subscriptions & Promotions			29,644	29,644		29,644		29,644			20
21	Clerical & General Office Expenses	256,836	8,033	108,884	373,753		373,753		373,753			21
22	Employee Benefits & Payroll Taxes			726,805	726,805	(15,431)	711,374		711,374			22
23	Inservice Training & Education			3,647	3,647		3,647		3,647			23
24	Travel and Seminar			15,270	15,270		15,270	2,672	17,942			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,912	30,912		30,912		30,912			26
27	Other (specify):* BAD DEBT			2,930	2,930		2,930	(2,930)				27
28	**TOTAL General Administration**	327,699	8,033	943,536	1,279,268	(15,431)	1,263,837	(1,063)	1,262,774			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,001,548	475,774	1,373,551	5,850,873	(15,431)	5,835,442	(1,063)	5,834,379			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			333,212	333,212	(42,288)	290,924		290,924			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,790	2,790		2,790	(764)	2,026			32
33	Real Estate Taxes			1,587	1,587		1,587		1,587			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			337,589	337,589	(42,288)	295,301	(764)	294,537			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,582		10,582		10,582		10,582			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,194	86,194		86,194		86,194			42
43	Other (specify):* SEE ATTACHED			163,040	163,040	57,719	220,759	(220,759)				43
44	**TOTAL Special Cost Centers**		10,582	249,234	259,816	57,719	317,535	(220,759)	96,776			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,001,548	486,356	1,960,374	6,448,278		6,448,278	(222,586)	6,225,692			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(764)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(805)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,930)	27		24
25	Fund Raising, Advertising and Promotional	(135,428)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(82,659)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (222,586)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (222,586)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/1/99

Ending: 9/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VILLA INDEPENDENT LIVING UNIT	$ (85,331)	43	1
2	OUT OF STATE TRAVEL	(932)	19	2
3	2000 TRAVEL COSTS PAID 1999	3,906	19	3
4	2001 TRAVEL & SEMINAR COSTS PAID 2000	(302)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(82,659)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	1,867	0	0	0	0	0	0	0	0	0	0	1,867	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,930)	0	0	0	0	0	0	0	0	0	0	(2,930)	27
28	**TOTAL General Administration**	(1,063)	0	0	0	0	0	0	0	0	0	0	(1,063)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,063)	0	0	0	0	0	0	0	0	0	0	(1,063)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SUNSET HOME **#** 0011643 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(764)	0	0	0	0	0	0	0	0	0	0	(764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(220,759)	0	0	0	0	0	0	0	0	0	0	(220,759)	43
44	**TOTAL Special Cost Centers**	(220,759)	0	0	0	0	0	0	0	0	0	0	(220,759)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(222,586)	0	0	0	0	0	0	0	0	0	0	(222,586)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MERCANTILE		X	OPERATIONS LINE OF CREDIT		8/3/00	$ 150,000	$ 150,000		0.0850	$ 2,026	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 150,000	$ 150,000			$ 2,026	9
	B. Non-Facility Related*											
10	GIFT ANNUITIES		X	NONE							764	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 764	14
15	TOTALS (line 9+line14)						$ 150,000	$ 150,000			$ 2,790	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	1,587	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,587	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	1,587	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

REAL ESTATE TAXES ON LAND HELD FOR EXPANSION

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,745 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

VILLA APARTMENTS 16-2 BEROOM UNITS 16,000 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-1997	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		1958	1958	$ 394,000	$ 7,880	50	$ 7,880	$	$ 333,700	4
5	138		1971	1971	1,218,562	24,371	50	24,371		706,739	5
6	49		1972	1972	472,577	9,452	50	9,452		271,738	6
7	5		1987	1987	68,497	3,425	20	3,425		44,810	7
8											8
	Improvement Type**										
9	FIXED EQUIPMENT			1971	814,827					814,827	9
10	FIXED EQUIPMENT			1972	253,064					253,063	10
11	FIXED EQUIPMENT			1978	280,726	11,229	25	11,229		252,895	11
12	FIXED EQUIPMENT			1979	13,938					13,938	12
13	FIXED EQUIPMENT			1980	3,693	148	25	148		3,042	13
14	FIXED EQUIPMENT			1984	23,531					23,531	14
15	FIXED EQUIPMENT			1985	119,185	5,996	5,10,15,20	5,996		93,211	15
16	FIXED EQUIPMENT			1986	20,518	800	10,15	800		20,098	16
17	FIXED EQUIPMENT			1987	12,320	564	10,15,20	564		9,761	17
18	FIXED EQUIPMENT			1988	11,218	241	10,20	241		9,455	18
19	FIXED EQUIPMENT			1989	4,670	311	15	311		3,579	19
20	FIXED EQUIPMENT			1990	600	30	20	30		310	20
21	FIXED EQUIPMENT			1993	259,307	14,040	10,20	14,040		101,884	21
22	FIXED EQUIPMENT			1995	188,017	9,657	10,15,20	9,657		50,289	22
23	FIXED EQUIPMENT			1996	10,809	1,037	10,15	1,037		4,013	23
24	2 AO SMITH GAS BOILERS			1997	30,000	1,500	20	1,500		5,250	24
25	9 KEYPADS WITH ZONE CARDS (DOORS)			1997	2,343	156	15	156		391	25
26	CALL IGHT SYSTEM 2 WEST			1999	5,340	178	15	178		178	26
27	SMOKE DETECTORS DINING ROOMS 2,3,4,			2000	2,524	84	15	84		84	27
28	POWER WIRING UPGRADE EMERGENCY GENERATOR			2000	10,100	253	20	253		253	28
29	REPLACE SEPARATOR KITCHEN CHILLER			2000	2,720	68	20	68		68	29
30	NEW CHILLER REPLACEMENT			2000	208,923	5,223	20	5,223		5,223	30
31	KEY LOCKS AND WINDOW PULLS			2000	2,160	72	15	72		72	31
32	ALZHEIMER UNIT (NOT YET APPROVED)			2000	2,437,862		30				32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 6,872,031	$ 96,715		$ 96,715	$	$ 3,022,402	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	6 DUCT DETECTORS			1997	3,118	156	20	156		390	9
10	4 JANITOR CLOSET DOORS			1998	2,605	130	20	130		326	10
11	FIRE ALARM LOUDER			1998	12,884	859	15	859		2,147	11
12	WEST ELEVATOR RENOVATION			1998	4,500	225	20	225		563	12
13	GENERATOR LOAD BANK			1998	24,518	1,226	20	1,226		3,065	13
14	35.98 TON AIR COOLED CHILLER SO BLDG			1998	25,357	1,690	15	1,690		4,125	14
15	NORTH ELEVATOR RENOVATION			1998	63,500	3,175	20	3,175		7,938	15
16	FIRE ALARM CONTROL PANEL			1998	7,142	357	20	357		893	16
17	2 HOUR FIRE WALL IN VERTICAL SHAFTS			1998	64,994	3,250	20	3,250		8,045	17
18	CHILLER 35.8 TON MODIFICATION			1999	10,257	684	15	684		1,026	18
19	UPGRADE 4S&N FIRE ALARM MODULES			1999	3,404	170	20	170		255	19
20	BUILDINGS & IMPROVEMENTS			1958	12,000					12,000	20
21	BUILDINGS & IMPROVEMENTS			1972	51,124	1,023	50	1,023		28,636	21
22	BUILDINGS & IMPROVEMENTS			1979	13,639	273	50	273		5,867	22
23	BUILDINGS & IMPROVEMENTS			1977	14,179					14,179	23
24	BUILDINGS & IMPROVEMENTS			1978	442,103	8,842	50	8,842		199,060	24
25	BUILDINGS & IMPROVEMENTS			1980	1,185	38	10,20	38		1,185	25
26	BUILDINGS & IMPROVEMENTS			1981	13,075					13,075	26
27	BUILDINGS & IMPROVEMENTS			1982	14,161					14,161	27
28	BUILDINGS & IMPROVEMENTS			1983	17,260	863	20	863		14,946	28
29	BUILDINGS & IMPROVEMENTS			1984	2,492					2,492	29
30	BUILDINGS & IMPROVEMENTS			1985	294,277	7,357	40	7,357		112,917	30
31	BUILDINGS & IMPROVEMENTS			1986	13,199	379	25,40	379		5,536	31
32	BUILDINGS & IMPROVEMENTS			1987	328,956	14,819	15,20	14,819		235,923	32
33	BUILDINGS & IMPROVEMENTS			1988	36,315	239	10,20	239		34,546	33
34	BUILDINGS & IMPROVEMENTS			1989	164,241	7,313	10,20	7,313		103,445	34
35	BUILDINGS & IMPROVEMENTS			1990	64,734	3,237	20	3,237		33,404	35
36	TOTAL (lines 4 thru 35)				$ 1,705,219	$ 56,305		$ 56,305	$	$ 860,145	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDINGS & IMPROVEMENTS			1992	11,222	967	10,20	967		7,710	9
10	BUILDINGS & IMPROVEMENTS			1993	37,801	2,214	5,10,20	2,214		19,142	10
11	BUILDINGS & IMPROVEMENTS			1994	9,466	382	5,20	382		4,310	11
12	BUILDINGS & IMPROVEMENTS			1995	105,756	8,204	5,10,15	8,204		45,882	12
13	BUILDINGS & IMPROVEMENTS			1996	43,599	4,838	5,10,20	4,838		21,210	13
14	BLINDS GARDEN ROOM			1997	935	94	10	94		327	14
15	CARPET GARDEN ROOM			1997	1,154	231	5	231		808	15
16	REMODEL GARDEN ROOM			1997	44,549	2,227	20	2,227		7,888	16
17	CERAMIC FLOOR EMPLOYEE DINING ROOM			1997	1,907	95	20	95		334	17
18	CARPET MAIN DINING ROOM			1997	8,323	1,665	5	1,665		5,826	18
19	BLINDS DECK/LOUNGE			1997	2,490	249	10	249		872	19
20	CARPET DECK/LOUNGE			1997	8,485	1,697	5	1,697		5,940	20
21	REMODEL DECK/LOUNGE			1997	332,574	16,629	20	16,629		58,200	21
22	2 DRAPES DINING ROOM			1997	1,056	106	10	106		264	22
23	6 HUNTER BLINDS DINING ROOM			1997	638	64	10	64		160	23
24	DRAPES 257&259			1997	998	100	10	100		250	24
25	BLINDS MEDICAL RECORDS ROOM			1997	978	98	10	98		245	25
26	REMODEL FIRST FLOOR LOBBY			1998	99,145	4,957	20	4,957		12,393	26
27	CARPET FIRST FLOOR LOBBY			1998	3,163	633	5	633		1,582	27
28	DRAPES FIRST FLOOR LOBBY			1998	1,449	145	10	145		362	28
29	BLINDS FIRST FLOOR LOBBY			1998	662	66	10	66		166	29
30	REMODEL 257&259			1998	2,585	129	20	129		323	30
31	DRAPES 457 & 271 WEST			1999	986	99	10	99		148	31
32	BLINDS ROOM 157 & MINIS ICE CREAM SHOP			1999	710	71	10	71		107	32
33	VERTICAL BLINDS OFFICE 1 WEST			1999	1,988	199	10	199		298	33
34	FIRE PROTECTION BOXES			2000	23,606		20				34
35	TILE 1ST WEST & 1ST SOWEST HALLS			2000	4,632		10				35
36	TOTAL (lines 4 thru 35)				$ 750,857	$ 46,159		$ 46,159	$	$ 194,747	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS:										9
10	FOUNTAIN			1975	2,807	96	25	96		2,807	10
11	FLAG POLE			1978	495					495	11
12	PARKING LOT & CURB			1979	6,425					6,425	12
13	1992 IMPROVEMENTS			1992	56,865	5,687	10	5,687		49,303	13
14	1995 IMPROVEMENTS			1995	25,890	2,400	5,12	2,400		15,685	14
15	GRAVEL 500 WASHINGTON			1996	1,893	379	5	379		1,704	15
16	GRAVEL 501-503 WASHINGTON			1997	4,000	800	5	800		2,800	16
17	BRICK WALL 5TH WASHINGTON			1997	4,800	192	25	192		672	17
18	PARKING LOT A & B 500,5001,5003 WASHINGTON			1999	44,219	3,685	12	3,685		5,527	18
19	FIRE HYDRANT			2000	5,383	1,794	15	1,794		1,794	19
20	LANDSCAPE WHITE ROCK 4TH ST			2000	3,784	1,892	10	1,892		1,892	20
21	LANDSCAPE YARD			2000	1,700	850	10	850		850	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	ROUNDING				(5)	(6)		(6)		(4)	35
36	TOTAL (lines 4 thru 35)				$ 158,256	$ 17,769		$ 17,769	$	$ 89,950	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 507,231	$ 57,744	$ 57,744	$	5 to 25	$ 317,071	37
38	Current Year Purchases	137,071	6,704	6,704		5 to 15	6,704	38
39	Fully Depreciated Assets	127,807					127,807	39
40	DISPOSED ASSETS		3,747	3,747		5,10		40
41	TOTALS	$ 772,109	$ 68,195	$ 68,195	$		$ 451,582	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	MAINTENANCE	97 3/4 TON & PLOW	1997	$ 23,521	$ 5,781	$ 5,781	$	4	$ 14,453	42
43	RESIDENT TRANSPORT	FORD BUS	1990	34,485				4	34,485	43
44	RESIDENT TRANSPORT	1994 DODGE VAN	1994	19,796				4	19,796	44
45	RESIDENT TRANSPORT	1994 FOR VAN	1995	36,216				4	36,216	45
46	TOTALS			$ 114,018	$ 5,781	$ 5,781	$		$ 104,950	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 10,561,197	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 290,924	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 290,924	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,723,776	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	VILLA INDEP LIVING UNITS	$ 1,677,631	$ 42,288	$ 498,942	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 1,677,631	$ 42,288	$ 498,942	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 8,219	$		$ 8,219	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			3,559			3,559	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			4,023			4,023	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				10,582		10,582	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 15,801	$ 10,582		$ 26,383	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 161,196	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	379,865		3
4	Supply Inventory (priced at COST)	53,959		4
5	Short-Term Investments	306,687		5
6	Prepaid Insurance	21,723		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 923,430	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	270,441		12
13	Land	188,707		13
14	Buildings, at Historical Cost	9,486,363		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	886,127		16
17	Accumulated Depreciation (book methods)	(4,723,776)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,399,176		21
22	Other Long-Term Assets (specify):	2,914,559		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,421,597	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,345,027	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 132,874	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000		29
30	Accrued Salaries Payable	344,751		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	RETAINAGE PAYABLE	232,192		36
37	EST HEALTH CLAIMS INCURRED	26,965		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 886,782	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	REFUNDABLE FEES	177,100		43
44	DEFERRED REVENUES	62,036		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 239,136	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,125,918	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,219,109	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,345,027	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,082,144	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,082,144	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	136,965	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 136,965	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,219,109	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,186,249	1
2	Discounts and Allowances for all Levels	(522,580)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,663,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,170	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,600	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,770	23
	D. Non-Operating Revenue		
24	Contributions	395,576	24
25	Interest and Other Investment Income***	377,163	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 772,739	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE LIST ATTACHED	144,065	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 144,065	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,585,243	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,560,670	31
32	Health Care	3,010,935	32
33	General Administration	1,279,268	33
	B. Capital Expense		
34	Ownership	337,589	34
	C. Ancillary Expense		
35	Special Cost Centers	173,622	35
36	Provider Participation Fee	86,194	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,448,278	40
41	**Income before Income Taxes (line 30 minus line 40)****	136,965	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 136,965	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,179	2,251	$ 50,885	$ 22.61	1
2	Assistant Director of Nursing	1,831	2,144	42,681	19.91	2
3	Registered Nurses	10,464	11,334	189,397	16.71	3
4	Licensed Practical Nurses	77,218	86,127	1,003,861	11.66	4
5	Nurse Aides & Orderlies	127,353	139,315	1,189,024	8.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,623	10,199	106,236	10.42	8
9	Activity Director	1,863	2,091	24,237	11.59	9
10	Activity Assistants	9,628	10,587	72,761	6.87	10
11	Social Service Workers	931	1,304	15,836	12.14	11
12	Dietician					12
13	Food Service Supervisor	3,726	4,350	58,778	13.51	13
14	Head Cook	5,447	6,431	54,317	8.45	14
15	Cook Helpers/Assistants	34,991	38,179	263,168	6.89	15
16	Dishwashers	5,787	6,449	50,767	7.87	16
17	Maintenance Workers	6,378	6,803	58,514	8.60	17
18	Housekeepers	24,827	27,712	193,470	6.98	18
19	Laundry	9,689	10,757	78,237	7.27	19
20	Administrator	2,094	2,410	70,863	29.40	20
21	Assistant Administrator					21
22	Other Administrative	10,286	11,351	140,622	12.39	22
23	Office Manager					23
24	Clerical	13,168	14,806	148,186	10.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,995	2,354	22,735	9.66	31
32	Other Health C: SEE ATTACHED	8,481	9,769	80,382	8.23	32
33	Other(specify) SEE ATTACHED	6,199	7,052	86,591	12.28	33
34	TOTAL (lines 1 - 33)	373,158	413,775	$ 4,001,548 *	$ 9.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,030	1-3	35
36	Medical Director		4,200	10-3	36
37	Medical Records Consultant		1,310	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,568	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,774	11-3	44
45	Social Service Consultant		1,774	12-3	45
46	Other(specify)				46
47	REHAB CONSULTANT		7,910	10a-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 28,566		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY KIRLIN	ADMINISTRATOR	0	$ 70,863
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,863

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
TIMOTHY J WIEWEL CPA	AUDITING/ACCTG	$ 12,342
SCHOLZ LOOS PALMER SIEBER	LEGAL	12,297
SCHOLZ LOOS PALMER SIEBER	LEGAL	805
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,444

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,266
Unemployment Compensation Insurance	26,694
FICA Taxes	313,289
Employee Health Insurance	127,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	115,729
DISABILITY INSURANCE	5,156
PHYSICALS	6,291
EMPLOYEE AWARDS	26,380
ADJUST FUND RAISING COSTS	(15,431)
TOTAL (agree to Schedule V, line 22, col.8)	$ 711,374

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,532
Advertising: Employee Recruitment	7,943
Health Care Worker Background Check	792
(Indicate # of checks performed 66)	
LIFE SERVICES NETWORK-DUES	8,005
TRI STAATES HEALTH COALITION	3,194
OTHER VARIOUS DUES	7,178
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14,338
2000 EXPENSES PAID 1999	3,906
2001 EXPENSES PAID 2000	(302)
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,942

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/99 Ending: 9/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 **Report Period Beginning:** 10/1/99 **Ending:** 9/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICES NETWORK $8,005

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 70,519 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 86,194
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? O
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: TIMOTHY J WIEWEL CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.